



AGING & DISABILITY NETWORK CONSUMER INTAKE FORM

The service you are receiving is paid for in whole or in part by funds from the federal Older American's Act and the State of Iowa. Your responses on this form are confidential. The Department on Aging uses this important information to research the needs of older Iowans. Thank you for providing your information.

Today's Date: _____

Last Name: _____ **First:** _____ **MI:** _____

Date of Birth: ____/____/____ or **Age:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home Phone: (____) _____ **Cell Phone:** (____) _____ **Email:** _____

Demographic Information

Do you live alone? ☐ Yes ☐ No

Number in Household: _____

Please Check Your Annual Total Household Income Range:

- | | | |
|--|--|--|
| <input type="checkbox"/> \$0 - \$11,880 | <input type="checkbox"/> \$11,881 - \$16,020 | <input type="checkbox"/> \$16,021 - \$20,160 |
| <input type="checkbox"/> \$20,161 - \$24,300 | <input type="checkbox"/> \$24,301 - \$28,440 | <input type="checkbox"/> \$28,441 - \$32,580 |
| <input type="checkbox"/> \$32,581 - \$36,730 | <input type="checkbox"/> \$36,731 - \$40,890 | <input type="checkbox"/> \$40,891 - or Above |

Veteran Status: ☐ Veteran ☐ Veteran Dependent/Spouse

Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ African American/Black
☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Primary Language: ☐ English Other: _____

Does Medicaid pay for some of the services you receive in your home, such as homemaker, transportation, organizing your medications, bathing assistance, or meals?

☐ Yes ☐ No ☐ Don't Know

In the past 30 days, how often were these statements true:

I have worried whether my food would run out before I got money to buy more.

☐ Often ☐ Sometimes ☐ Never

The food that I bought just didn't last and I didn't have money to get more.

☐ Often ☐ Sometimes ☐ Never

Consumer: _____

During the past 7 days, how would you rate your ability to complete these routine activities?

	I didn't need help	I needed help sometimes	I always needed help	Activity did not occur
Shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>IADL – Data Entry:</i>	Independent	Sometimes dependent or limited assistance	Totally dependent	

How would you rate your ability to complete these activities?

	I don't need help	I need help sometimes	I always need help	Activity does not occur
Manage Money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do heavy housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do light housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>IADL – Data Entry:</i>	Independent	Sometimes dependent or limited assistance	Totally dependent	

During the past 7 days, how would you rate your ability to complete these physical activities?

	I didn't need help	I needed help sometimes	I always needed help
Walk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get Out Of Bed Or Chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>ADL – Data Entry:</i>	Independent	Sometimes dependent or limited assistance	Totally dependent

Consumer: _____

Nutrition Risk Screening

- ☐ Yes ☐ No I have an illness or condition that made me change the kind and/or amount of food I eat.
- ☐ Yes ☐ No I eat fewer than two meals per day.
- ☐ Yes ☐ No I eat few fruits. (Less than 1 ½ cups daily)
- ☐ Yes ☐ No I eat few vegetables. (Less than 2 cups daily)
- ☐ Yes ☐ No I eat and/or drink few milk products. (Less than 3 cups daily)
- ☐ Yes ☐ No I have three or more drinks of beer, liquor or wine almost every day.
- ☐ Yes ☐ No I have tooth or mouth problems that make it hard for me to eat.
- ☐ Yes ☐ No I don't always have enough money to buy the food I need.
- ☐ Yes ☐ No I eat alone most of the time.
- ☐ Yes ☐ No I take 3 or more different prescribed or over-the-counter drugs a day.
- ☐ Yes ☐ No I have gained 10 pounds in the last 6 months, without wanting to.
- ☐ Yes ☐ No I have lost 10 pounds in the last 6 months, without wanting to.
- ☐ Yes ☐ No I am not always physically able to do one or more of: shopping, cooking, or feeding myself.

*This section to be completed by provider.*Provider / Site: _____
_____New Intake Form: ☐Updated Intake Form: ☐**Check the box next to the service provided:**

- | | | |
|---|--|---|
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Congregate Meals | <input type="checkbox"/> Home Delivered Meals |
| <input type="checkbox"/> Nutrition Counseling | <input type="checkbox"/> Nutrition Education | |